Dentist, Dr B

A Report by the

Health and Disability Commissioner

(Case 03/13742/WS)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer/Complainant
Dr B	Provider/Dentist
Dr C	Dentist
Dr D	Dentist
Dr E	Periodontist

Complaint

On 24 September 2003 the Commissioner received a complaint from Mrs A about the dental services she received from Dr B, dental surgeon, of a dental surgery. The issues arising from the complaint that were investigated are summarised as follows:

Whether Dr B provided dental services of an appropriate standard to Mrs A. In particular:

- *the appropriateness of treatment and extraction of tooth 36 on 24 June 2003*
- *the adequacy of the radiograph used by Dr B to assess the extent of the treatment needed on tooth 36.*

Whether Mrs A was able to make an informed choice and give informed consent to the extraction of tooth 36. In particular whether Dr B:

- *provided Mrs A with the treatment options available to her*
- *provided an environment to enable Mrs A to ask questions and decide on the most appropriate option before making a decision.*

An investigation was commenced on 28 November 2003.

Information reviewed

- Mrs A's letter of complaint to the New Zealand Dental Association dated 27 August 2003
- Mrs A's letter of complaint to the Commissioner dated 17 September 2003
- Further letter from Mrs A to the Commissioner dated 13 June 2004
- Documents from Mrs A including:
  a) copy emails to and from Dr D (2 July 2003);
  b) invoices for treatment at the dental surgery, with till receipts;
  c) copy dental records and proposed treatment plan from the dental surgery;

d) letter from Dr E dated 19 August 2003;
e) copy letter from Dr E to Dr D dated 15 August 2003;
f) letter from Mrs A's employer dated 30 June 2003;
g) letter from Dr B to ACC Medical Misadventure Unit dated 21 October 2003;
h) letter from Dr B to Mrs A dated 5 August 2003

- Letter from Dr B to the Commissioner dated 2 December 2003 including:
  a) copy letter from Dr B to the Regional Dental Association, dated 9 July 2003;
  b) copy letter from Dr B to ACC Medical Misadventure Unit dated 21 October 2003;
  c) copy letter from Dr B to Mrs A dated 5 August 2003;
  d) copy draft letter from the Regional Dental Association, dated 22 July 2003;
  e) copy dental records
- Further letter from Dr B to the Commissioner dated 30 January 2004
- Further letter from Dr B to the Commissioner dated 15 November 2004
- Mrs A's dental records from Dr D
- Letter from Dr E to Dr D dated 15 August 2003
- Decision letter from ACC Medical Misadventure Unit to Mrs A, with ACC advisors' reports.

Independent expert advice was obtained from Dr David Purton, restorative dentist.

Information gathered during investigation

Consultation — Dr C
In early June 2003, after tripping at home, Mrs A broke off a small piece of her left lower molar ("tooth 36"). Although her usual dentist is Dr D, on this occasion Mrs A canvassed other dentists in her local area to obtain an urgent appointment. She secured an appointment with Dr C, dental surgeon, at the dental surgery, for 1pm on 6 June 2003.

Dr C saw Mrs A and took two bitewing radiographs (X-rays). She observed two lesions on Mrs A's front teeth, which she indicated to her with a mirror. Dr C told Mrs A that she needed to make a second appointment to have fillings placed in those teeth and to have her teeth cleaned by the hygienist. Mrs A said she asked Dr C to read the X-rays, because she was concerned about her chipped tooth, but was told that this would be done at the second appointment, and the chip was "probably nothing". Mrs A recalled that this consultation lasted just eight minutes and cost $63.

Consultation — Dr B
At 10am on 24 June 2003, Mrs A saw Dr B, dental surgeon. Dr B is Dr C's sister; both are partners of the dental surgery. Because the previous consultation had been so short, Mrs A told Dr B that she was happy to have some dental treatment that day if necessary and was prepared to return on a later date for the remaining work to be done. The appointment was scheduled to last 30 minutes.

Mrs A asked Dr B to read the X-rays taken on 6 June and Dr B confirmed that a fragment of tooth was missing from the back left molar (tooth 36). Mrs A said that Dr B "drilled away quickly but then stopped and said that I would need a root canal. Then she changed her mind and said my tooth was extremely filled and she doubted it would last long after the root canal and a bridge would be the best choice." Dr B confirmed that she removed the previous restoration from tooth 36, and the loose amalgam (carious tooth tissue). She noted that there was pulp exposure, and stopped to explain to Mrs A that the tooth required either a root canal filling or extraction. Mrs A asked what her options for treatment were.

There is disagreement between Mrs A and Dr B as to the extent of information provided at this point in the consultation. Mrs A says Dr B told her a root canal would cost about $700 but would not last long because the tooth had already been extensively restored. Therefore, a bridge would be "the best choice" and would cost $2,500. According to Mrs A, Dr B dismissed an implant as being too expensive, without asking her what she could afford or what she wanted. Mrs A was particularly anxious to keep all her teeth, and says she "was going to insist on a root canal" when Dr B interrupted her and said "personally she would have it extracted and a bridge put in". Mrs A says she asked for more information and understood that if the tooth was extracted, a crown could then be put on each tooth either side of the extraction site, to hold a replacement tooth 36 in place. Mrs A recalled:

> "She [Dr B] obviously thought the information provided was sufficient because no more information was given after that. She acted with such confidence and authority staring down on me lying there, that I really felt I had no choice but to consent for the extraction."

Mrs A described Dr B's manner as "impatient and authoritative" and "biased", and says she felt "under pressure to go with [Dr B's] choice of treatment".

Dr B said she explained to Mrs A that "the tooth could be saved, however it was heavily filled, compromised and definitely would require crowning if endodontically treated". She stated:

> "The success rate for root canals [is] not 100% and it is always important for patients to know this. I also explained if the tooth was extracted, there were options to fill the gap … I told her what a bridge was, and that in my opinion, this was probably the best option, as her teeth either side of [the] gap (35, 37) were filled and thus would benefit from being capped. The implant option was given and I didn't dismiss it as 'too expensive' … merely that it was 'the most expensive' option.
>
> I have no qualms about doing implants, and have done many, so I was just explaining what my professional opinion was for her situation."

Dr B recalled telling Mrs A that she had "some bone loss" and quoting "upwards of $4000" for an implant. Dr B stated:

> "All the options were given to [Mrs A]. At no time was she forced to make a decision to get the tooth extracted at that appointment. Had she said at any time that she wanted

> to consider her options further, I would have placed a temporary filling and made another appointment for her.
>
> … She received quality care, and was given all information needed to make an informed decision."

Mrs A was not asked to sign a consent form for the extraction as this is not part of the consent process for simple extractions at Dr B's surgery. Dr B provided me with two pamphlets published by the New Zealand Dental Association ("NZDA"), which she said she gives to all patients at her surgery to inform them about treatment options. Copies are attached to this report as Appendix 1 and 2. I note that the pamphlets provide information about root canal treatment, and implant, bridge and denture replacement options. Dr B said: "I presume [Mrs A] read the pamphlet[s], she was given all information and I explained each option. She asked questions, which I answered fully."

Mrs A denied receiving or being shown any written literature about the treatment options available to her from Dr B.

The dental records for this consultation state:

> "Extraction 36:
>
> Clinical Notes: pulp exposure. [Patient] told re exo/endo — explained tooth compromised, would need crown if endo (not 100% success). Also told [patient] re bridge/implants if tooth extracted."

In addition, the following treatment plan was entered: "bridge 35–37".

Dr B extracted Mrs A's tooth 36. Afterwards, Mrs A asked to see her tooth and, on looking at it, was concerned that there was "a substantial amount of tooth left", which made her wonder whether the extraction had been inappropriate. She took the tooth with her when she left the surgery.

Mrs A paid $99 for this consultation. Her receipt records the time of payment as 10.16am. Mrs A also provided a letter from her employer confirming that she left work to attend this appointment at 9.55am. She had arrived at Dr B's surgery at 10am, and on this basis concluded that her entire appointment (including waiting time) had lasted just 16 minutes. Mrs A is concerned that this was too short a time in which to be able to make an informed decision about the extraction of a tooth.

On 27 June 2003 Mrs A consulted her usual dentist, Dr D. She showed him tooth 36, asked him about options for replacing it, and sought his opinion as to its extraction. Dr D's records state:

> "[Patient] had 36 extracted 2 days ago — told tooth unsaveable. [Patient] brought tooth in — was saveable! Discussed options — bridgework [$3,600], but 37 and 35 sound teeth, implant [$4,500]. [Patient] prefers implant."

On 2 July 2003, Mrs A sent an email to Dr D seeking confirmation of their discussion of 27 June. Her email stated:

> "I just want to make sure my understanding is correct:
>
> 1. You said the extracted tooth could have definitely been saved. I assume that means a root canal could have been performed and the tooth could have lasted a good many years with proper care and attention.
>
> 2. We discussed my options — bridge or implant. The bridge would mean grinding down two teeth on either side to fit crowns on so that they will support the false tooth. You felt that it would not be in my best interest to do this because my back molar is totally healthy and uncompromised, plus the other tooth is still in a very good state. Fitting crowns on them might produce problems later on because if either one of these teeth are compromised, then the integrity [of] the entire bridge is threatened. Given my age of 38 years and my expressed wish to keep my teeth as long as possible, you recommended that the implant was the best option."

In reply Dr D said:

> "Your summary is pretty much spot on —
>
> 1. I feel that the tooth most certainly could have been saved.
>
> 2. The implant would be the best long term option — it is independent of the adjacent teeth and does not depend on these teeth as bridge work does. Therefore if something goes wrong with either of the adjacent teeth then the implant is not affected. The bridgework option does involve heavy preparation of the adjacent teeth — ie a lot of perfectly sound whole tooth structure is lost irreversibly."

Dr D referred Mrs A to Dr E, periodontist. Mrs A first saw Dr E on 5 August 2003 when he considered the feasibility of a single tooth implant replacement into the tooth 36 site. He recommended that Mrs A have an implant placed once the extraction site had fully healed. In a letter to Dr D dated 15 August 2003, Dr E confirmed that Mrs A had "generalised marginal gingivitis, localised early periodontitis" but "good bony height" in the tooth 36 site.

Mrs A gave Dr E the pre-extraction X-rays taken by Dr C, and tooth 36, and sought his opinion on the extraction. Dr E wrote to Mrs A on 19 August 2003 and stated:

> "On the most recent radiograph just prior to extraction of the 36 (dated 6th month of 2003), decay is evident in the distal (back portion) of the molar tooth. On reviewing the extracted tooth, clearly treatment was attempted in the form of the excavation of the decay which had resulted in pulpal exposure of the distal pulpal horn of the root canal system. The remaining portion of the tooth, however, remains relatively intact and, on

> review of the X-rays, there will appear to be reasonably good bony support with only 1–2 mm of the bone loss beneath the CEJ radiographically.
>
> In light of this, recommended treatment should have been root canal therapy. The only other treatment option would have been extraction of the tooth.
>
> It is likely that if root canal treatment had been provided and subsequent restoration of the tooth undertaken, the prognosis for the 36 would have been good.
>
> Thus, in order of preference, most certainly root canal treatment and restoration of the 36 would precede extraction of the tooth, unless the coronal or crown structure of the tooth has been damaged to the point that restoration is no longer possible. I do not feel that this was the case for your molar tooth."

Mrs A advised me that both Dr D and Dr E also commented that the pre-extraction X-rays taken by Dr B were "overexposed".

Dr E placed an implant for Mrs A on 2 September 2003. On 10 September 2003, Mrs A attended a hygienist, because she was concerned about her periodontal condition, especially in light of Dr B's comments. Mrs A advised me that the hygienist told her that her lower teeth and periodontal tissues are generally healthy and any localised early periodontitis is primarily on her back upper molars.

Complaint to the Regional Dental Association

On 6 July 2003 Mrs A sent a letter of complaint to an official of the Regional Dental Association. This was forwarded to Dr B on 9 July 2003 for comment. On 14 July Mrs A met with the official and provided tooth 36 and the X-rays. Mrs A said the official told her tooth 36 had been "doomed for extraction" and that an implant might not work because of her "dental condition". At the conclusion of the meeting Mrs A asked the official to arrange for peer review of Dr B's dental treatment, particularly her decision to extract the tooth.

The Regional Dental Association official drafted a letter to Mrs A on 22 July 2003, and subsequently sent it to Dr B, who provided it to the Commissioner's Office. The letter was not sent to Mrs A, but Dr B understood that the Regional Dental Association official had discussed its contents with Mrs A. I note that the contents of the letter do reflect the summary of the 14 July meeting between the official and Mrs A, which Mrs A outlined in her complaint to my Office. The official's draft letter read as follows:

> "Your extracted tooth shows evidence of decay into the pulp chamber. Of the options given to you by [Dr B], namely root canal or extraction, I agree with [Dr B] on viewing your X-rays that a root canal filling of your lower left first molar tooth was a bad option and that the tooth was best extracted. This is due to the presence of periodontal disease in your mouth, loss of bone around the tooth, the heavily filled nature of the tooth and the presence of decay on the root surface of the tooth.

> You have written in your letter that [Dr B] had given you the options of root canal or extraction, but recommended extraction before she removed the tooth. The fact that you allowed [Dr B] to extract the tooth on the day assumes that you agreed with [Dr B's] recommendation. It is unfortunate that you then had second thoughts afterwards.
>
> You asked me last week if there was any other avenue for your complaint. Unfortunately this complaint is not [in] the realms of [either] peer review or the HDC.
>
> [Dr B] has since offered to refund the money for your extraction. I would accept this offer and recommend that in the future if you are faced with a similar situation, ask the dentist if you can think about things first or seek a second opinion.
>
> As far as the future replacement of an implant goes, it is more important for you to see and receive treatment for your periodontal condition than how soon you get an implant (if that is deemed to be the most appropriate replacement option by your periodontist). An implant can not be placed if there is periodontal disease, nor is it recommended to place bridgework.
>
> I reinforce the need for you to contact a periodontist as soon as possible to address the bone loss, present around several of your teeth."

On 5 August Dr B wrote to Mrs A, enclosing a cheque for $162 (representing a refund of the cost of both Mrs A's consultations at the dental surgery). In that letter, Dr B said:

> "I am sorry you were upset with the treatment you received at our surgery. I am hoping to resolve this. I am sorry that you felt afterwards that my explanation was inadequate, or you felt intimidated into having the tooth out. I went ahead with the extraction as you did agree to have it done. Under no circumstances, whatsoever, would I proceed with treatment if I felt you were not happy for this.
>
> The tooth in question, your lower left first molar, was in fact very compromised. It was heavily filled, had periodontal problems, with a lot of bone loss evident. The presence of decay on the root surface of the tooth just added to its problems. I definitely feel that extraction was in fact the best option for this tooth."

Those observations were not recorded in Dr B's clinical notes, and Mrs A confirmed that they were not conveyed to her during the consultation on 26 June. Mrs A was angry that this letter was signed not by Dr B but by an unidentified person on her behalf.

On 26 August 2004, Mrs A received a call from the Regional Dental Association and was informed that it had decided that the events giving rise to her complaint did not warrant peer review of Dr B's practice. Mrs A decided not to pursue her complaint any further with the Regional Dental Association but redirected her concerns to the Dental Council of New Zealand ("DCNZ").

Accident Compensation Corporation

Mrs A also lodged a medical misadventure claim with ACC. The Medical Misadventure Unit considered whether Dr B had given Mrs A sufficient information and time to make an informed decision regarding the future of tooth 36 prior its extraction.

A dental surgeon examined tooth 36 and reviewed Dr C's pre-operative radiographs. He advised ACC that the treatment of choice for tooth 36 would have been root canal therapy and restoration, ideally a crown. The dental surgeon noted that Dr D and Dr E had also concluded that this was the preferred treatment option. Had Mrs A declined this, then extraction and subsequent replacement was the alternative.

A prosthodontist advised ACC that while the pre-extraction X-rays showed considerable caries on the distal aspect of tooth 36, removal of the caries would have left a deep cavity but would not have made the tooth unrestorable. Based on radiographic appearance alone, he concluded that the tooth could have been saved. Having reviewed the extracted tooth, he confirmed that the tooth was "certainly restorable". He said that "it would have required root canal therapy, and it would have required at least some sort of cuspal overlay restoration. The distal margin would have been very deep but not so deep to make this an impossible situation to deal with."

The prosthodontist noted the conflict in the accounts of Dr B and Mrs A as to what was discussed prior to extraction and stated:

> "One thing is clear and that is that [Mrs A] wished to retain her teeth if at all possible, and she has demonstrated this by proceeding to have an implant placed to make good the loss of the tooth, albeit at her own expense. There is no doubt that she verbally consented to have the tooth removed, but this is normal practice in such circumstances. The central issue to this case therefore is whether this consent was truly 'informed consent'."

The prosthodontist concluded that had Mrs A been given all of the information she required, including that the tooth was in fact able to be restored, she would have chosen that option, rather than have the tooth removed. Accordingly he concluded that Dr B had failed to obtain Mrs A's informed consent and that she had provided treatment that was inappropriate, although the treatment in itself was carried out correctly.

Based on the advice of its experts, ACC accepted Mrs A's claim, concluding that the failure to follow a thorough informed consent process constituted medical error on the part of Dr B.

Independent advice to Commissioner

The following expert advice was obtained from Dr David Purton, a restorative dentist.

"I have been asked to advise the Commissioner whether [Mrs A] received an appropriate standard of dental care from [Dr B] – case number 03/13742.

I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I am a Senior Lecturer at the University of Otago School of Dentistry. I have specialist registration with the Dental Council of New Zealand as a Restorative Dentist. My qualifications are BDS (Otago) MDS (Otago) and FRACDS.

I have had 11 years of general dental practice experience, 3 years of hospital dental practice and 14 years of full-time teaching at the University of Otago. I treat my own patients and I teach under-graduate and post-graduate students. Relevant to this case is my regular clinical supervision and teaching of 4th year undergraduates in endodontic (root canal) treatment and fixed prosthodontics (crowns and bridges). I am fully conversant with the techniques and standards expected of dentists when they graduate with the BDS degree from the University of Otago.

Complaint

[Mrs A's] complaint is detailed in her complaint letter to the Commissioner. The issues investigated are summarised as follows:

Whether [Dr B] provided dental services of an appropriate standard to [Mrs A]. In particular:

- the appropriateness of treatment and extraction of tooth 36 on 24 June 2003
- the adequacy of the radiograph used by [Dr B] to assess the extent of the treatment needed on tooth 36.

Whether [Mrs A] was able to make an informed choice and give informed consent to the extraction of tooth 36. In particular whether [Dr B]:

- provided [Mrs A] with the treatment options available to her
- provided an environment to enable [Mrs A] to ask questions and decide on the most appropriate option before making a decision.

Supporting Information

Section A

- [Mrs A's] complaint to the Commissioner, forwarded by [DCNZ], dated 22 September 2003 (pages 1-18).

- Copies of e-mails from [Mrs A] to [Dr D] and [Dr D's] reply dated 2 July 2003.
- Letters from [Dr E] to [Dr D] dated 15 August 2003 and to [Mrs A] dated 19 August 2003.
- Invoices and dental records from [Dr C] and [Dr B] dated in June and July 2003.
- A statement from [Mrs A's employer] dated June 2003.
- Letter from [Dr B] to [Mrs A] dated 5 August 2003.

Section B

- The Commissioner's notification letter to [Dr B], dated 28 November 2003 (pages 19-21).

Section C

- [Dr B's] response to the Commissioner's investigation, dated 2 December 2003 (pages 22-28)
- Letter from [Dr B] to [the Regional Dental Association] dated 9 July 2003.
- Letter from [Dr B] to [ACC] dated 21 October 2003.
- Letter from [the Regional Dental Association] to [Mrs A] dated 22 July 2003.

Section D

- Letter from [Investigations Manager, HDC] to [Dr B] dated 29 January 2004.
- [Dr B'S] response to additional questions, dated 30 January 2004.

Section E

- [Mrs A'S] dental records from [Dr D] (pages 32-33).

Additional evidence – extracted tooth, photographs and radiographs.

Expert Advice Required

The purpose is to advise the Commissioner on whether [Dr B] provided services of an appropriate standard and in addition answer the following questions:

- What particular standards apply in this case and did [Dr B's] treatment comply with those standards? Please explain.
- Were the radiographs taken by [Dr C] of an appropriate standard?
- Does the radiograph show extensive bone loss around tooth 36?
- Is there evidence of heavy filling in tooth 36?
- Did tooth 36 require extraction, and if not what would have been [Mrs A] treatment options? Please comment.

Any other matter which, in your opinion, should be brought to the Commissioner's attention.

Background

[Mrs A] advised the Commissioner that she went for a check up on 6 June 2003 with dentist, [Dr C]. [Dr C] told her that she needed two fillings and a teeth clean. [Dr C] also took radiographs which had not been developed before [Mrs A] left the surgery.

At 10.00am on 24 June 2003 [Mrs A] attended her follow-up appointment with [Dr B], [Dr C's] sister. She asked [Dr B] whether the radiographs revealed a fragment of tooth missing from her back molar. [Mrs A] maintains that [Dr B] started drilling and told her she needed a root canal. [Dr B] then changed her mind and said that the tooth would not last long with a root canal and she required a bridge. [Dr B] explained about the root canal filling, the bridge and implant dentistry. According to [Mrs A], [Dr B] extracted the tooth leaving her little time to consider the treatment options or give consent.

[Mrs A] had an appointment with her usual dentist on 27 June 2003 who informed her that the extracted tooth could have been saved and an implant would be the best long-term solution. He also told her that the two teeth [Dr C] marked for treatment had some old fillings that were just starting to break down but did not need any immediate attention.

What particular standards apply in this case and did [Dr B's] treatment comply with those standards?

The standard best applied in this case is the NZDA Code of Practice *Informed Consent* accepted by the NZDA Board in September 2001. This standard begins by stating that 'The dentist has an ethical responsibility to inform his/her patient on treatment options, to help the patient arrive at the most appropriate treatment plan and thus gain their consent.' The Code also notes that 'While this Code seeks to define and clarify informed consent, much is still left to the dentist's professional judgement.'

The criteria for informed consent are listed as:

1. Information on which to make a decision
2. Comprehension of the information
3. Competence to make a decision
4. Clear recommendations and advice by the dentist
5. Absence of pressure or coercion
6. Patient's decision

The information to be given (1 above) includes (edited for brevity):

1. The nature, status and purpose of the treatment or procedure including its benefits
2. The prognosis
3. Probable outcomes
4. All significant risks and their probability

5. Possible complications
6. Probable consequences of not receiving the treatment
7. All relevant management options/alternatives with their probable effects and outcomes
8. Name and status of the operator
9. Other information requested by the person to receive the proposed treatment

[Dr B's] management did not comply with this standard. [Mrs A] was not given sufficient information to satisfy the above criteria for informed consent. I base this on the patient's statements, the duration of the dental appointment (16 minutes), and [Dr B's] written justification for the extraction.

There appears to have been no information given on the prognosis of the root canal treatment and crown that could have been done for tooth 36. [Dr B] stated in her letters to the ACC [page 25] and the [Regional Dental Association] [page 24] that she told the patient 'The success rate of root canals is not 100%'. She did not state what the success rate actually is. She stated in the same letters 'I told her what a bridge was ...' and 'The implant option was given'. However this is not sufficient information to satisfy the requirements of the NZDA Code of Practice. The patient was not informed of all of the relevant management options/alternatives and probable effects and outcomes of bridges or of implant-retained crowns.

In addition the patient reported feeling under pressure to agree to the dentist's treatment proposal. The patient stated 'She acted with such confidence and authority staring down on me lying there, that I felt I had no choice but to consent to the extraction' [page 2]. The two parties disagree. [Dr B] stated in her letter to [ACC] [page 25], in reference to the patient, that 'At no time was she forced to make a decision to get the tooth extracted at that appointment'. *Pressure* in this context is entirely subjective and while I accept that the dentist didn't intend to produce this effect, nonetheless the patient felt under pressure.

Were the radiographs taken by [Dr C] of an appropriate standard?

The radiographs were of an appropriate diagnostic standard.

Does the radiograph show extensive bone loss around tooth 36?

Extensive is an imprecise term but in my opinion the radiograph does not show extensive bone loss. This opinion is shared by [Dr E], Periodontist. In his letter of 18/8/03 to [Mrs A] [page 11] he stated '… there would appear to be good bony support with only 1–2mm of bone loss … '.

The amount of bone loss should not have been used as an indication for extraction.

The patient has pointed out the illogicality of the argument that the bone loss around the tooth was an indication for extraction and that the bridge replacing it should be retained by teeth with the same pattern of bone loss [page 7].

Is there evidence of heavy filling in tooth 36?

Heavy is an imprecise term but acceptable in this case. The tooth certainly had a large filling and would have required a complex restoration, ideally a crown, for its long-term survival. However neither *heavy* nor *large* contribute very much to the argument here. The key point is that the tooth was restorable. The extent of the filling should not have been used as an indication for extraction.

Did tooth 36 require extraction, and if not what would have been [Mrs A's] treatment options? Please comment.

Tooth 36 did not require extraction. As described above there were no strong periodontal (bone loss) or restorative (filling) indications for extraction. An option would have been root canal treatment, a core restoration and a crown.

Sjögren et al. (1990) reported a success rate of 96% for root canal treatments done in similar circumstances. (Sjögren U, Hagglund B, Sundqvist G, Wing K. Factors affecting the long-term results of endodontic treatment. *Journal of Endodontics* 16:498–504, 1990).

Aquilino and Caplan (2002) reported a 10 year survival estimate of 89% for root-treated teeth with crowns. (Aquilino SA, Caplan DJ. Relationship between crown placement and the survival of endodontically treated teeth. *Journal of Prosthetic Dentistry* 87: 256–263, 2002).

Similar success rates have been reported in a number of studies from USA, Australia and Europe. We do [not] have data specific to New Zealand. With appropriate care therefore the prospects for successful treatment of tooth 36 were high.

Accepting that there was a low but recognisable risk of failure of the root canal and crown option, the question must be asked, would extraction of the tooth and provision of a bridge have benefited the patient in some other way? [Dr B] justified the bridge proposal in her letter to [HDC] dated 30/1/04 [page 31] by stating that 'Teeth either side of [the] tooth in question were heavily filled. A bridge would, in effect, restore these teeth also.' In her letter to [the Regional Dental Association] [page 24] she stated '... this was the best option as teeth either side of the gap (35, 37) were filled and thus would benefit from being capped'. To [ACC] [page 25] she wrote that she had told the patient that '... this was probably the best option ...' for the same reason.

However from the radiographs and photographs supplied to me, tooth 37 either has no fillings or perhaps a very small tooth-coloured filling confined to the enamel on one surface. The tooth appears to have no decay. [Dr D] who has examined the patient annotated the photograph of tooth 37 with 'Totally healthy with no dental work done'. However rather confusingly on another occasion in an e-mail to [Mrs A] [page 9] he stated that 'The 2 teeth marked for treatment do have old fillings that are just starting to

break down but when I examined them I felt that they do not need attention at the present'.[1] Tooth 35 has two fillings but they present little or no threat to the survival of the tooth. Five or six of the patient's other teeth are restored to a similar extent. The choice of the bridge cannot be justified on the basis of any benefit that would have accrued to other teeth.

Therefore extraction could not be justified for any dental reason. Dentists often extract teeth in this state for reasons such as: the patient cannot afford to pay, is not interested in retaining the tooth, or is unable to attend appointments. None of these circumstances seem to apply here as the patient has demonstrated by embarking on an expensive and lengthy course of treatment to replace the missing tooth.

Summary

[Dr B's] management of the case was not of an appropriate standard in that she did not fulfil the criteria for informed consent as described by the NZDA Code of Practice.

Tooth 36 did not require extraction. The option of root canal treatment and a crown would have offered very good prospects of success."

[1] The Commissioner notes that Dr D's remarks, quoted here by Dr Purton, related to Mrs A's two front teeth which Dr C had identified as requiring treatment, and not in fact to tooth 35 or 37.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.
2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

RIGHT 5
Right to Effective Communication

1) Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.
2) Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.

RIGHT 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including —

…

b) an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option;

…

RIGHT 7
Right to Make an Informed Choice and Give Informed Consent

1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.

Other relevant standards

New Zealand Dental Association "Code of Practice — Informed Consent" (accepted by NZDA Board September 2001):[2]

> **"INTRODUCTION**
> The dentist has an ethical responsibility to inform his/her patient on treatment options, to help the patient arrive at the most appropriate treatment plan and thus gain their consent …
>
> **CRITERIA FOR INFORMED CONSENT**
> 1. Information on which to make a decision.
> 2. Comprehension of the information.
> 3. Competence to make a decision.
> 4. Clear recommendations and advice by the dentist.
> 5. Absence of pressure or coercion.
> 6. Patient's decision (note age of consent) …
>
> **DEFINITIONS**
> **Information**
> All relevant information and likely outcomes and possible complications leading from diagnosis. Information should be focused on the patient's need for information, be truthful and in language the patient can understand …
>
> **ORAL AND WRITTEN CONSENT**
> … If verbal consent is all that is deemed necessary, it is prudent to note this in the records.
>
> In all situations keep careful, clear, written records.
>
> **TREATMENT FEES AND COSTS**
> Any discussion on 'informed consent' should include costs of dental services (ie fees for the services), affordability (the ability of the patient to actually pay for the treatment), and the value (the patient's assessment of the cost of care based on the importance and relevance of the treatment to the patient).
>
> No dentist should prejudge a patient's ability to afford a particular treatment, nor the value that the patient puts on the treatment. A dentist is required to discuss the cost,

[2] In May 2004, NZDA updated this Code of Practice, with significant input from the Commissioner's Office. The Commissioner understands that the updated version has recently been received by the DCNZ and is likely to be endorsed by the Council. Given that the events about which Mrs A has complained occurred before May 2004, the Code of Practice referred to in this report is that which was initially approved in April 1995, amended in 1996 and August 2001 and accepted by the NZDA Board in September 2001, ie the version also relied upon by Dr David Purton.

determine the fee level that the patient will be comfortable with in relation to treatment options — all of which must be outlined. This means the relative value of the proposed treatment to that patient. 'Informed consent' therefore, requires the patient to understand the delicate balance between cost, affordability and value.

INFORMATION TO BE GIVEN
1. The nature, status (whether it is orthodox or developmental) and purpose of the treatment or procedure, including its expected benefits.

2. The likelihood of achieving that purpose: the prognosis …

7. All relevant management options/alternatives with their probable effects and outcomes.

INFORMED CONSENT: NZDA GUIDELINES
Give a realistic assessment to the patient — the good news and the bad news. It is the patient's entitlement to know both sides. The patient must make their decision and give consent on your advice and information — be straightforward.

Some Examples of Areas which Need Special Care in Communication …

Endodontics
- Options available
- Success rates …

Restorative
- Heavily filled teeth
- Deep restorations
- Possibilities of cuspal fracture … or of pulpal involvement
- Give a realistic prognosis …

Periodontology
- Do a periodontal examination at the initial visit … RECORD THE RESULTS
- Record non compliance with oral hygiene instructions …

Implants
- The option of implants should be considered with patients, not only the full or partially edentulous, but also when standing teeth are seriously compromised."

Opinion: Breach – Dr B

Under Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) Mrs A had the right to have dental services provided by Dr B with reasonable care and skill. Pursuant to Right 7(1), services could only be provided if Mrs A had made an informed choice and given her informed consent. While the NZDA's Code of Practice on informed consent in place at the time set out some of the requirements expected of dentists when obtaining a patient's consent, it is important to note that Rights 5, 6 and 7 of the Code set out specific statutory obligations, which impose a higher standard on providers, particularly with regard to the type and detail of information that a patient is entitled to receive.

Mrs A's complaint raises two particular issues for determination: whether the extraction was clinically appropriate; and whether Dr B gave Mrs A sufficient information about her treatment options to enable her to give *informed* consent.

Appropriateness of extraction
On 24 June 2003, Dr B saw Mrs A for the first time. She examined Mrs A's tooth 36, and noted that it was fractured. She appears to have told Mrs A that she needed to drill the tooth before forming an assessment of its viability. Having removed the previous restoration and loose amalgam, Dr B noted that there was pulp exposure and formed the view that Mrs A had two treatment options for tooth 36 – extraction followed by a bridge placement, or restoration by way of a root canal filling.

Dr B's recommendation to Mrs A that the tooth be extracted was based on her clinical view that the tooth was "very compromised" and her belief that root canal fillings are not always successful. In her letter of 5 August, Dr B stated: "[Tooth 36] was heavily filled, had periodontal problems, with a lot of bone loss evident. The presence of decay on the root surface of the tooth just added to its problems. I definitely feel that extraction was in fact the best option for this tooth." These observations are not recorded in Dr B's clinical notes and were not conveyed to Mrs A during the consultation. Moreover, they are not supported by the clinical evidence subsequently assessed by Mrs A's treating clinicians and the expert advisors to the Commissioner and ACC.

Dr E viewed Mrs A's extracted tooth and Dr C's X-rays, and assessed Mrs A's oral health. He observed that Mrs A had only "generalised marginal gingivitis, localised early periodontitis" and "reasonably good bony support with only 1–2 mm of the bone loss" around the tooth 36 site. He noted that the tooth showed decay in the distal portion but was relatively intact and the recommended treatment should have been root canal therapy. This opinion was endorsed by the dental surgeon and prosthodontist advising ACC, and Dr Purton, advising the Commissioner.

Dr Purton's advice is especially compelling. He stated that there were no strong periodontal (bone loss) or restorative (filling) indications for extraction and "the key point is that the tooth was restorable". The condition of Mrs A's tooth and her overall oral health meant that root canal treatment and restoration of tooth 36 (ideally, with a crown)

were preferable to extraction as the clinically appropriate treatment option. Literature cited by Dr Purton notes a success rate of 96% for root canal treatments in similar circumstances and a ten-year survival estimate of 89% for root-treated teeth with crowns. He concluded that with appropriate care, the prospects for successful treatment of Mrs A's tooth 36 were high. Had Mrs A declined this option (having been appropriately informed), extraction and replacement was the alternative.

Dr B's recommended treatment plan following the extraction was the insertion of a bridge involving teeth 35 and 37. She justified this proposal on the basis of her view that those teeth were "heavily filled" and a bridge would "in effect, restore these teeth also". This plan was discussed with Mrs A and recorded in the clinical notes.

Dr Purton questioned the clinical appropriateness of this plan because in his view Mrs A's teeth 35 and 37 were not "heavily filled" but were healthy and sound. He stated: "Accepting that there was a low but recognisable risk of failure of the root canal and crown option, the question must be asked, would extraction of the tooth and provision of a bridge have benefited the patient in some other way?" He observed that tooth 35 had two fillings which "present little or no threat to the survival of the tooth" and tooth 37 had "no fillings or only a very small tooth-coloured filling confined to the enamel on one surface" and no decay. (Dr D also noted that tooth 37 was "totally healthy with no dental work done".) Inserting a bridge would have involved the heavy preparation of these teeth to the extent that much of the whole, sound tooth structure would have been irreversibly lost. On this basis, Dr Purton concluded that Dr B's proposed plan to use a bridge could not be justified on the basis of any benefit that would accrue to other teeth.

Dr Purton went on to consider whether there was any other reason to have recommended taking this course of treatment. He commented: "Dentists often extract teeth in this state for reasons such as: the patient cannot afford to pay, is not interested in retaining the tooth, or is unable to attend appointments. None of these circumstances seem to apply here as the patient has demonstrated by embarking on an expensive and lengthy course of treatment to replace the missing tooth."

I accept Dr Purton's advice that Dr B's decision to extract Mrs A's tooth 36 was not justified. In my view, it was a clinically inappropriate decision, compounded by an inappropriate proposed treatment plan. Dr B failed to observe the standard of care and skill expected of a dental surgeon when making these decisions, and breached Right 4(1) of the Code.

Informed consent

There is no doubt that Mrs A gave her verbal consent to the extraction of tooth 36 by Dr B. However, the key issue is whether that consent was properly informed. Informed consent is a process, involving open, honest, and effective communication (Right 5), and the provision of information that a reasonable patient, in that patient's circumstances, would expect to receive — including an explanation of the options available, and an assessment of the expected risks, side effects, benefits, and costs of each option (Right 6(1)(b)). Services may be provided only if the patient has made an informed choice and given

informed consent (Right 7(1)). As Dr Purton has noted, the statutory obligations set out in the Code are reinforced by the NZDA Code of Practice, which highlights the "ethical responsibility" of a dentist to inform the patient about treatment options, "to help the patient arrive at the most appropriate treatment plan". The fact that Mrs A's consent was not recorded in writing is not critical in determining whether it was "informed consent" in terms of the Code (which requires consent to be evidenced in writing only in the circumstances set out in Right 7(6)), although the extent to which Dr B recorded her clinical decisions and the proposed treatment in Mrs A's notes is a matter I have taken into account.

Mrs A was booked for a 30-minute consultation with Dr B on 24 June 2003, yet it appears the appointment lasted only 16 minutes. Mrs A complained that in this short space of time Dr B could not have provided sufficient information to enable Mrs A to make an informed decision. I agree that if Dr B reviewed the X-rays, started work on tooth 36, discussed options with Mrs A, administered anaesthetic and extracted the tooth, all within 16 minutes, then minimal time must have been allowed for a full discussion of treatment options and agreement on a treatment plan. However, in terms of the Code, the more important issue is whether, within that time, Dr B took steps to enable effective communication with her patient and provided the information that a reasonable patient, in Mrs A's circumstances, would expect to receive. That information should have included an accurate, balanced assessment of the management and treatment options for tooth 36, any particular reasons for or against each option, and the likely prognosis if they were taken. Explaining the likely cost of each option was just one aspect of the overall discussion.

I accept that Dr B did convey to Mrs A what her options were, ie a root filling with a crown, or extraction followed by either a bridge or an implant. Dr B's records and Mrs A's recollection confirm this. However, I am not satisfied that those options were carefully or fully presented by Dr B so that Mrs A could fully consider them and make an informed choice before treatment began. In respect of this issue I have borne in mind Dr Purton's comment that Dr B's professional judgement as to whether informed consent had been obtained is an important factor. Accordingly, I note Dr B's statement that had Mrs A said "at any time" that she wanted to consider her options further, she would have placed a temporary filling and made another appointment. I accept that Mrs A in fact *had* said at the start of the appointment that she was prepared to return for further work if necessary. Dr B appears not to have listened properly to Mrs A or asked her what she wanted — had she done so she would have known how anxious Mrs A was to retain all her teeth. In my view, Dr B's actions show a lack of professional judgement.

Further, Mrs A's comments that Dr B provided her with information in an abrupt, impatient, authoritative, and "biased" fashion are cause for concern. Mrs A says she felt "under pressure to go with [Dr B's] choice of treatment". I agree with Dr Purton that "pressure" in this context is "entirely subjective" and I am satisfied that Dr B did not intend to produce this effect. However, Mrs A's comments, and particularly her statement that she was going to "insist" on a root canal when Dr B "interrupted" her and said she would have the tooth extracted if she was in Mrs A's position, indicate that Dr B failed to create an environment that was conducive to effective dentist–patient communication.

The options for treatment of tooth 36, and Mrs A's ongoing oral hygiene, required "special care in communication" in terms of the NZDA Code of Practice because they included endodontics, restorative work, periodontics and implants. They ranged in price and complexity. Dr B gave Mrs A limited information about these options and appears to have focused primarily on the cost of each. She failed to give a realistic prognosis or a balanced assessment of the risks and benefits of the most clinically appropriate option, ie a root canal. Although she advised Mrs A that "the success rate of root canals is not 100%", she did not specify the success rate. However, the advice of Dr Purton, the experts advising ACC, Dr D and Dr E is clear — the long-term prognosis for tooth 36 with a root canal and a crown was good. This was vital information that Mrs A needed to be told.

Dr B gave Mrs A the impression that she should discount the placement of an implant at the tooth 36 site after extraction, because it was either the "most expensive" option or "too expensive". However, the NZDA Code of Practice specifically advises that "[n]o dentist should prejudge a patient's ability to afford a particular treatment, nor the value that the patient puts on the treatment. A dentist is required to discuss the cost, determine the fee level that the patient will be comfortable with in relation to treatment options — all of which must be outlined. This means the relative value of the proposed treatment to that patient." Dr B inaccurately judged the value Mrs A placed on retaining her teeth – a matter that has been highlighted by Mrs A's subsequent actions in retaining the services of Dr E to fit an implant for her.

I consider that Dr B showed a further lack of judgement in presuming that Mrs A had read the NZDA pamphlets on root canal fillings and bridge work. It is unclear when these pamphlets were provided to Mrs A, if at all. However, it is clear that if Mrs A had been given sufficient opportunity to fully consider the information they contained, and had she received sufficient accurate verbal information from Dr B — including that tooth 36 was in fact able to be restored — she would have chosen to have a root canal rather than have the tooth removed.

It is unclear what reasons Dr B actually gave to Mrs A during the consultation for preferring placement of a bridge on teeth 35 and 37, before recording this in the dental records as the proposed treatment plan. Aside from the issue of cost, Dr B appears not to have given Mrs A any clinical reasons for this option. The dental records do not refer to the alleged extensive bone loss around tooth 36, periodontal disease, or extensive restorations on teeth 35 and 37 to which Dr B subsequently referred in her responses to Mrs A's complaint and on the basis of which she sought to justify her clinical decision. In any event, these conditions were not apparent to the clinicians and experts who subsequently viewed the X-rays and extracted tooth, or to Dr E who visually examined Mrs A's dentition less than a month after the extraction. As Dr Purton noted, Dr B's argument that bone loss around tooth 36 was an indication for extraction makes it illogical for her to argue that a bridge was the preferred option for replacing that tooth. Nor is her argument that teeth 35 and 37 would benefit from being capped credible, since these were both healthy, sound teeth.

I consider that Dr B failed to provide a fair, accurate and balanced assessment of alternative options for the replacement of tooth 36, and to keep careful, clear records setting out the discussion and decision process. Ultimately, the way in which Dr B obtained Mrs A's consent to treatment was inadequate and inappropriate, and fell well short of what is required to gain a patient's informed consent. It also constituted a departure from appropriate professional and ethical standards expected of dentists under the NZDA Code of Practice. Accordingly, in my opinion, Dr B breached Rights 4(2), 6(1)(b) and 7(1) of the Code.

Opinion: No breach – Dr B

Mrs A is concerned that the X-rays to which Dr B referred prior to the extraction were "overexposed" and insufficient to enable an accurate assessment of the treatment required. She has asked why Dr B did not take further X-rays on 24 June before beginning treatment and believes that had she done so, "the correct treatment" might have been provided.

From the dental records available it is evident that Mrs A had two bitewing radiographs (X-rays) taken by Dr C on 6 June 2003. These were not viewed by Dr C before Mrs A left the consultation that day. The "Proposed Treatment Plan" and price estimate given to Mrs A by Dr C confirms that there were "X-rays to see" at the next appointment, ie, on 24 June. The remainder of the treatment plan does not refer to tooth 36 but to the need for composite fillings in two front teeth (teeth 21 and 22).

Dr B's entries in Mrs A's dental records do not refer to further X-rays being taken on 24 June. Accordingly, I conclude that the X-rays to which she referred before beginning treatment that day were those taken on 6 June. Dr B formed the impression from viewing the X-rays that Mrs A needed work on tooth 36 and proceeded to physically examine that tooth. My expert, Dr Purton, advised that the X-rays "were of an appropriate diagnostic standard". There is no evidence (for example, in the correspondence of Dr D and Dr E) to confirm Mrs A's claim that the X-rays were "overexposed", nor is there evidence that the treatment provided by Dr B was compromised as a result of viewing them. Consideration of X-rays is one element of a dentist's formulation of a treatment plan — others are the visual and manual examination of the patient's teeth. Shortly after starting work on tooth 36, having removed the previous restoration and existing caries, Dr B formed a view about her patient's treatment options. I consider it unlikely that had Dr B taken additional X-rays on 24 June, her clinical decision would have been different. There is therefore no breach of the Code in relation to this issue.

Other comments

The advice that the Regional Dental Association official gave to both Mrs A and Dr B is of concern. His comments — expressed in a draft letter to Mrs A and conveyed to her when they met — demonstrate a lack of understanding of the requirements of the informed consent process, the provisions of the Code, and the role of the Commissioner. While I accept that the draft letter was never sent to Mrs A (because, according to his handwritten note on the draft, "it is outside the realms of official concern") it is concerning that he apparently advised the complainant: "It is unfortunate that you … had second thoughts [after the extraction]" and "in the future if you are faced with a similar situation, ask the dentist if you can think about things first or seek a second opinion". It was also inappropriate for the official to send the draft to Dr B.

Recommendations

I recommend that Dr B:

- apologise to Mrs A for her breaches of the Code. This apology should be in writing and signed by Dr B herself, and is to be sent to the Commissioner for forwarding to Mrs A;

- review her practice in light of this report, particularly how she provides information to her patients and obtains their informed consent.

Follow-up actions

- I propose to refer this matter to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

- A copy of this report will be sent to the Dental Association with a recommendation that it advise me of its complaints process.

- A copy of this report will be sent to the Dental Council of New Zealand.

- A copy of this report, with details identifying the parties removed, will be sent to the New Zealand Dental Association and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes, upon completion of the Director of Proceedings' processes.

Appendix 1

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Root Canal Treatment

Inside a tooth is a fine space called the root canal. The root canal contains the dental pulp which consists of nerves and blood vessels. If the dental pulp becomes diseased or dies a toothache or an abscess may occur. In the past these problem teeth were extracted but now your dentist can offer you root canal treatment to care for these teeth.

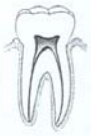
Is root canal treatment painful?

Local anaesthetic and modern painkillers are used to provide comfortable treatment. Usually painful symptoms improve once treatment is started.

How is a tooth restored following root canal treatment?

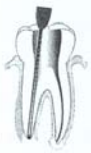
It is very important that any restoration adequately seals the root filling from infection by bacteria from the mouth.

Teeth requiring root canal treatment often have large fillings or extensive damage and will require a crown to restore them properly. These teeth are also weaker and the added protection of a crown is recommended.



Healthy tooth

Tooth with dental abscess



File in place to clean and shape root canal

Root canal treatment completed and tooth crowned

How successful is root canal treatment?

If the root canals are able to be fully cleaned and sealed and the tooth properly restored then treatment has a very high success rate.

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The treatment may take several visits to complete with temporary fillings and dressings placed in the tooth between visits. Antibiotics are sometimes prescribed when an infection is present.

What complications can occur during root canal treatment?

Because the root canals are very fine and curved in some teeth it may be difficult to clean the canals completely. Occasionally a piece of a file may break off in the root canal due to the strain placed on these fine instruments. Sometimes these are retrievable but they may also be sealed in the root canal as part of the filling.

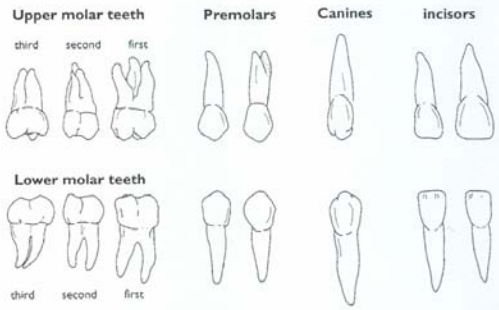
Pain or discomfort may occur between appointments due to ongoing tenderness of the tissues around the tooth or a flare up of an abscess, or a hair-line crack in the root.

An abscess or ongoing pain will rarely persist following root canal treatment. If this occurs the tooth will require some further treatment.

Occasionally a surgical procedure may be required if discomfort persists.

What is the cost?

Your dentist will be able to give you an estimate after a thorough examination. The cost will depend on the difficulty and the time spent treating the tooth.



Roots of teeth vary in number, size and shape

To find out which treatment is best for you, and the costs involved, talk to your dentist.

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Appendix 2

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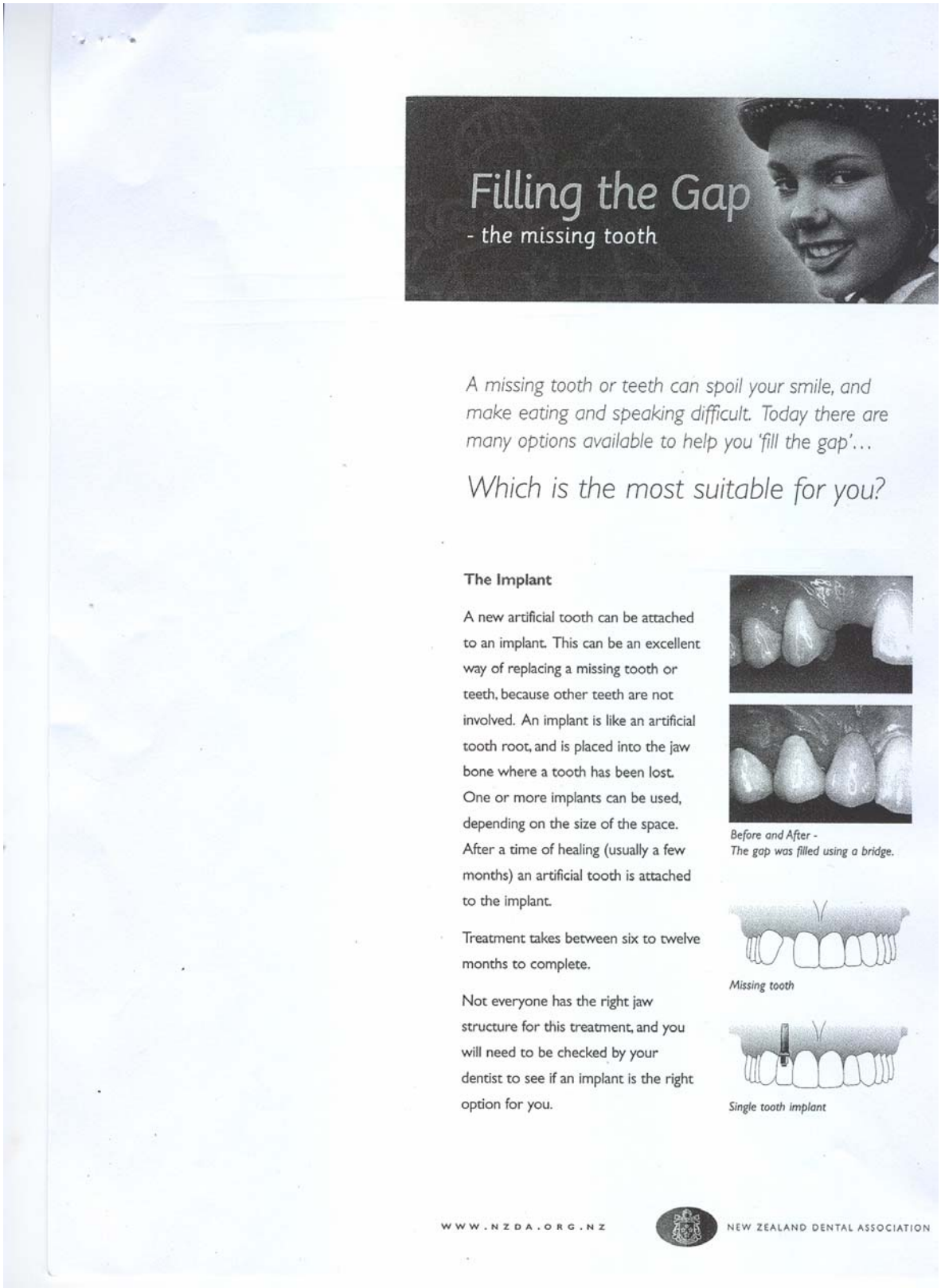

Filling the Gap
- the missing tooth

A missing tooth or teeth can spoil your smile, and make eating and speaking difficult. Today there are many options available to help you 'fill the gap'...

Which is the most suitable for you?

The Implant

A new artificial tooth can be attached to an implant. This can be an excellent way of replacing a missing tooth or teeth, because other teeth are not involved. An implant is like an artificial tooth root, and is placed into the jaw bone where a tooth has been lost. One or more implants can be used, depending on the size of the space. After a time of healing (usually a few months) an artificial tooth is attached to the implant.

Treatment takes between six to twelve months to complete.

Not everyone has the right jaw structure for this treatment, and you will need to be checked by your dentist to see if an implant is the right option for you.

Before and After -
The gap was filled using a bridge.

Missing tooth

Single tooth implant

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Addendum

The Director of Proceedings considered this matter and decided not to issue proceedings before the Dentists Disciplinary Tribunal or the Human Rights Review Tribunal.

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